

1                                   **STATE OF RHODE ISLAND**  
2                                   **AND PROVIDENCE PLANTATION**

3  
4                                   **OFFICE OF THE HEALTH INSURANCE COMMISSIONER**  
5

6   IN RE:           BLUE CROSS & BLUE SHIELD   :  
7                    OF RHODE ISLAND CLASS DIR   :  
8                    NOVEMBER 15, 2007           :

9                                   **PRE-FILED DIRECT TESTIMONY OF**  
10                                  **JOHN LYNCH**

11  
12   **I.       INTRODUCTION**

13                   Q.     Please state your name and professional qualifications.

14                   A.     My name is John Lynch. I am a Fellow of the Society of Actuaries and a  
15   Member of the American Academy of Actuaries.

16                   Q.     By whom are you employed?

17                   A.     I am employed by Blue Cross & Blue Shield of Rhode Island (Blue  
18   Cross).

19                   Q.     What is your title and area of specialization as an employee of Blue  
20   Cross?

21                   A.     My title is Chief Actuary and I oversee Blue Cross' Actuarial and  
22   Underwriting departments. A key responsibility of these areas is developing and maintaining  
23   premium rate structures that are actuarially sound, competitive in the marketplace and meet the  
24   company's financial and operational goals. My duties also include setting claim reserve levels  
25   and overseeing all other actuarial and underwriting functions.

26                   Q.     How long have you been employed by Blue Cross in that capacity?

1                   A.     I have been employed in that capacity for the last 2 years. I was hired into  
2     this position on July 27, 2005.

3                   Q.     Have you previously qualified and been accepted as an expert on actuarial  
4     matters in proceedings before the Office of Health Insurance Commissioner (OHIC)?

5                   A.     Yes, last year I was accepted as an actuarial witness and testified as such  
6     at the rate hearing pertaining to Blue Cross' request to increase rates for class DIR. Additionally  
7     numerous filings have been submitted to the OHIC over my signature during the last 2 years.  
8     [Offer as an expert witness on actuarial rate matters.]

1     **II.     DESCRIPTIONS AND BACKGROUND INFORMATION.**

2                     Q.     I am showing you a document marked as Blue Cross Exhibit 1 for  
3     identification purposes. Would you please explain what this is?

4                     A.     Yes. This is a letter, dated November 15, 2007, that I wrote to the Health  
5     Insurance Commissioner notifying him of the filing of new subscription rates by Blue Cross for  
6     Class DIR and summarizing the content and purpose of the filing, which accompanied that letter.

7                     Q.     Is Blue Cross Exhibit 1 for identification an accurate summary of Blue  
8     Cross' filing for new Direct Pay subscription rates?

9                     A.     Yes.

10                    Q.     Would you please briefly describe the Class DIR classification?

11                    A.     Yes. Class DIR is the rating classification for enrolled subscribers who  
12     are neither eligible for employer based coverage (other than as a self employed individual) nor  
13     State or Federal programs at the time of enrollment and who have enrolled in one of the  
14     individual products. Enrollment is either through direct application or through conversion from  
15     prior group coverage.

16                    Two rating pools are employed: (a) Basic rates (Pool I), utilizing specific  
17     community rates for all subscribers under age 65 and for subscribers ages 65 and older; and (b)  
18     Preferred rates (Pool II), with rates determined on the basis of the age and gender of the  
19     subscriber. An annual open enrollment period is conducted for the Basic (Pool I) plan, while  
20     enrollment under the Preferred (Pool II) plan is available continuously throughout the year for  
21     applicants passing a health screening. Additionally Pool I is open for enrollment continuously  
22     throughout the year for HIPAA eligibles regardless of their health status.

1 Products currently available under Basic (Pool I) and Preferred (Pool II) include  
2 HealthMate Coast-to-Coast Direct Plan 400/800 ("HealthMate Direct 400"), HealthMate Coast-  
3 to-Coast Direct Plan 2000/4000 ("HealthMate Direct 2000"), HealthMate for HSA Direct Plan  
4 3000/6000 ("HealthMate for HSA 3000") and HealthMate for HSA Direct Plan 5000/10000  
5 ("HealthMate for HSA 5000"). A general description of these products is included in Mr.  
6 Thomas Boyd's policy testimony.

7 Q. When was the last rate increase implemented for the Direct Pay Class?

8 A. The last rate increase was effective April 1, 2007. This was the result of a  
9 filing for Class DIR that was submitted to the OHIC on November 20, 2006. On February 21,  
10 2007 the rate filing was approved with some modifications.

11 Q. As a result of the February 21, 2007 decision by the OHIC, can you  
12 quantify what the modifications were that were made?

13 A. Yes. The required rate increase was reduced by 3.8% along with some  
14 stipulations on some policy actions.

15 Q. Was there disagreement with the actuarial development or assumptions  
16 identified in the decision?

17 A. No. There was not any disagreement with the actuarial development or  
18 assumptions.

19 Q. I am showing you a document marked as Blue Cross Exhibit 2 for  
20 identification. Would you please identify it?

21 A. These are actuarial schedules that were enclosed with Exhibit 1 and  
22 submitted as support of the calculation of the required rates for both Basic (Pool I) and Preferred

1 (Pool II). They apply to Class DIR for the rate year commencing April 1, 2008. Blue Cross  
2 Exhibit 2 consists of Schedules 1 through 58.

3 Q. I am showing you a document marked as Blue Cross Exhibit 3 for  
4 identification. Please describe what is contained in this document.

5 A. Blue Cross Exhibit 3 is entitled "Trend and Comparison Supplement  
6 Submitted in Conjunction With the Direct Pay Rate Filing Effective April 1, 2008." This exhibit  
7 compares trends used in the current and previous Direct Pay filings with actual historical claims  
8 trends and industry average rating trends. Also included in this exhibit is a comparison of Blue  
9 Cross' medical loss ratios, administrative expenses, and premium rates and benefits to other  
10 regional plans offering coverage to the individual market.

11 Q. Are the required rates the same for comparable products between Basic  
12 (Pool I) and Preferred (Pool II)?

13 A. No. As I indicated previously, Basic (Pool I) utilizes community rates,  
14 while Preferred (Pool II) rates vary by the underwritten subscriber's age and gender.  
15 Furthermore, the development of their respective required rates in this filing reflects some of the  
16 difference in claims expense levels experienced between Basic (Pool I) and Preferred (Pool II).

17 Q. How does this difference in claims expense levels experienced by Blue  
18 Cross between Basic (Pool I) vs. Preferred (Pool II) affect the respective required rates?

19 A. It causes the underlying level of the Preferred (Pool II) rates to be  
20 relatively lower, and correspondingly the level of the Basic (Pool I) rates to be relatively higher.

21 Q. Does this reflection of a portion of the difference in experience between  
22 pools affect the overall aggregate amount of premium revenue required by Blue Cross for Class  
23 DIR in total?

1 A. No. The aggregate premium revenue required is unchanged.

2 Q. Does the fact that only a portion of the experience difference is utilized to  
3 separate the rates for the two pools imply that one pool has some subsidization effect on the  
4 other pool?

5 A. That is correct. The Basic rates (Pool I) are subsidized to some degree by  
6 the Preferred (Pool II) rates.

7 Q. How did Blue Cross determine the amount of subsidy that the Preferred  
8 rates (Pool II) should provide to the Basic rates (Pool I)?

9 A. In setting the relationships for this rating period we reviewed the  
10 experience of the pools separately. The Basic pool (Pool I) experience on its own indicated that  
11 a 26% increase was necessary. The Preferred pool (Pool II) experience indicated that a 15%  
12 decrease was possible. As discussed in the Health Insurance Commissioner's Decision of  
13 February 21, 2007, the OHIC stated that a good way to determine the subsidy that Pool II rates  
14 provide to Pool I might be to set a target loss ratio of 70% for Pool II. However, if we had set  
15 the Pool II loss ratio to 70%, the required rate increase for Pool I would have been 21% while the  
16 required Pool II rates would have decreased by 5%. We felt this was too large a reduction in the  
17 cross subsidy between the pools to make in any one year and too large a rate increase to ask of  
18 Pool I subscribers. Instead we decided we would limit the Pool I increase to 15%. In order to  
19 meet the overall premium requirements of the Direct Pay pool, this decision meant that a Pool  
20 II rate increase of 8% would be required. This rate adjustment is expected to produce a Pool II  
21 loss ratio of less than 70%. We feel this is compliant with OHIC's previous Direct Pay rate  
22 decision, which states in part, "Going forward, the rating process should be modified to establish

1 a target loss ratio for Pool II at approximately 70%, with adjustments to that benchmark as  
2 deemed necessary or appropriate by Blue Cross.”  
3

4 Q. Did you prepare or cause to be prepared Blue Cross Exhibit 1 for  
5 identification and the actuarial schedules attached thereto, marked as Blue Cross Exhibit 2?

6 A. Yes. These rate calculations and the actuarial assumptions and  
7 methodology underlying the required rates were developed under my direction by the actuarial  
8 staff at Blue Cross.

9 Q. Are you of the opinion that these rate calculations and the actuarial  
10 assumptions and methodology underlying these required rates are actuarially sound?

11 A. Yes.

12 Q. Would you please describe in general terms the purpose of this filing?

13 A. The purpose of the filing is to seek approval of new subscription rates to  
14 be effective for the April 1, 2008 billing cycle. The filing schedules are intended to provide  
15 actuarial justification for the required rates needed by Blue Cross in order for the products to be  
16 financially self-supporting, both in the interest of its subscribers and its mission to provide  
17 quality health insurance programs.

18 The required subscription rates must provide for the expected costs of the  
19 products and contribute to the financial needs of Blue Cross. Such required rates are intended to  
20 provide sufficient income during the new rate period to cover the costs of subscribers' incurred  
21 claims for this period and to administer the programs. In addition, the required rate levels must  
22 include a contribution to reserve component that will contribute Class DIR's fair share toward

1 maintaining corporate reserves at an adequate level. The required rates also provide subscribers  
2 an investment income credit.

3 Q. Would you please describe, in general terms, any product changes being  
4 proposed in connection with the subscription rates developed in this filing?

5 A. Yes. There are two product changes being proposed with this filing. First,  
6 we are proposing that our HealthMate Direct 2000 Plan be designated a Wellness Health Benefit  
7 Plan ("WHBP") effective April 1, 2008, the beginning of the new rate year. This program will  
8 provide subscribers the opportunity to receive a reward of 10% of annual premiums if they meet  
9 certain wellness requirements. Second, we are proposing to add a Specialty Pharmacy network  
10 with a \$75 co-payment on specialty drugs to our HealthMate Direct 400 and HealthMate Direct  
11 2000 plans. This Specialty Pharmacy program is designed to help control costs on some of the  
12 most expensive pharmaceuticals in the market. More details on these programs are provided in  
13 the testimony of Mr. Thomas Boyd and Dr. Augustine Manocchia.

14 Q. Does Blue Cross propose any rate structure changes with either the Basic  
15 (Pool I) or the Preferred (Pool II) subscription rates that have been developed in this filing?

16 A. No.

17 Q. Would you please describe the enrollment changes in Class DIR over the  
18 past few years?

19 A. Yes. As of December 2005 there were approximately 15,600 members  
20 enrolled in Class DIR. Preferred (Pool II) represented about 42% of the total enrollment at that  
21 time. As of December 2006 there were approximately 14,200 members enrolled in Class DIR.  
22 As of October 2007, there were approximately 14,000 members enrolled in Class DIR with  
23 Preferred (Pool II) representing about 47% of the total.

1 Q. What is the significance of the Preferred (Pool II) percentage?

2 A. Assuring that Preferred (Pool II) is attractive in the market is critical to  
3 sustaining the Direct Pay market. The financial stability of the entire Class DIR is dependent to  
4 a significant degree on the continuing ability of Blue Cross to attract subscribers into Preferred  
5 (Pool II) since they help to subsidize Basic (Pool I). As a consequence, it is important that  
6 Preferred (Pool II) rates bear a reasonable relationship to the pool's own underlying experience  
7 level and not be higher than necessary, in order to balance attractiveness in the market with some  
8 continuing subsidy of Basic (Pool I). The entire Class DIR pool would be on a financially  
9 sounder basis if the Pool I subsidy could be generated from a smaller Pool II surcharge collected  
10 from a larger Pool II enrollment. Since the percentage of Pool II members in the Direct Pay  
11 population has increased from 42% at December 2005 to 47% at October 2007, it appears that  
12 the steps Blue Cross has taken in recent years to encourage Pool II enrollment, such as gradually  
13 reducing its subsidy of Pool I rates and making Pool II subscribers eligible for the Premium  
14 Assistance Program, are having their intended effects.

15 Q. OHIC's previous Direct Pay rate decision included a recommendation from the  
16 hearing officer that Blue Cross examine its medical underwriting standards for Pool II to ensure  
17 that they are not too strict. Can you please tell us what steps you have taken in this area?

18 A. Medical underwriting is used to determine eligibility for a preferred rate  
19 (Pool II) in our Direct Pay products. It is based on self reported information in the application,  
20 augmented, when it is available, by any prior claim history we may have on the applicant and,  
21 when necessary, additional information from the applicant's physician. This information is  
22 translated into a risk assessment on the applicant through the use of a standard industry medical  
23 manual. The manual recommends underwriting actions of accept or reject based on medical

1 history. It is our practice to monitor these underwriting actions to ensure that guidelines are  
2 consistently applied and to identify the source of any aberrations if identified. We believe that  
3 our guidelines strike the correct balance between qualifying as many people as possible for Pool  
4 II while at the same time keeping its risk pool relatively “clean” in order to keep Pool II rates as  
5 low as possible. In order to ensure the accuracy of our rating process, we have recently  
6 purchased a new medical underwriting manual that incorporates more recent evaluation criteria.  
7 We are currently in the process of testing it and anticipate transitioning to the new manual in  
8 early 2008.

9 Q. Let us turn now to Blue Cross Exhibit 2, namely the actuarial schedules  
10 enclosed with the filing letter marked as Exhibit 1. Please describe for us of what Schedules 1  
11 through 4 consist.

12 A. Schedules 1 through 4 constitute the table of contents for the actuarial  
13 Schedules in Exhibit 2 that display and support the calculations of the required subscription rates  
14 for the April 1, 2008 billing cycle for Class DIR. The actuarial Schedules are grouped into  
15 sections, labeled as Section I through Section IX.

16 Q. Please describe briefly what is contained in each of these ten sections.

17 A. Section I consists of Schedules 5 through 10, which summarize the  
18 calculations of the Basic (Pool I) monthly subscription rates for the April 2008 billing cycle.  
19 The monthly subscription rates for each of the Class DIR products for Basic (Pool I) subscribers  
20 are displayed separately for those under age 65 vs. ages 65 and over, and by Individual vs.  
21 Family contract type.

22 Section II consists of Schedules 11 through 16, which summarize the calculations  
23 of the Preferred (Pool II) required monthly subscription rates for the April 2008 billing cycle.

1 These schedules display the monthly subscription rates for each of the Class DIR products for  
2 Preferred (Pool II) subscribers by age, gender, and Individual vs. Family contract type.

3 Section III consists of Schedules 17 through 23, which summarize the calculation  
4 of the Basic (Pool I) and Preferred (Pool II) monthly base rates for each of the products. This  
5 includes the development of the required rates for the two pools within Class DIR overall, so that  
6 they can be experience-adjusted.

7 Section IV consists of Schedules 24 through 28, which summarize the claims  
8 impacts from state assessments. Schedule 25 shows a summary of the overall impacts of each  
9 assessment, while the subsequent schedules show the detail behind each one.

10 Section V consists of Schedules 29 through 38, which show the projected claims  
11 by plan for Direct Pay and calculate the rate period projected incurred claims expense for Basic  
12 (Pool I) and Preferred (Pool II) subscribers. Schedule 30 summarizes the projected claims  
13 expense by pool and plan for Direct Pay while Schedules 31 through 38 calculate the projected  
14 claims expense by plan for Basic (Pool I) and Preferred (Pool II).

15 Section VI consists of Schedules 39 through 45, which summarize the  
16 calculations of the Radiology Management savings factor and net-to-allowed factors for each of  
17 the four current products. Schedule 40 calculates the Radiology Management savings factor.  
18 Schedules 41 through 44 calculate the medical (non-drug) net-to-allowed factors for the  
19 HealthMate Direct 400 and HealthMate Direct 2000 products and the composite net-to-allowed  
20 factors for the HealthMate for HSA 3000 and HealthMate for HSA 5000 plans. Schedule 45  
21 calculates the net-to-allowed factors for the free-standing prescription drug benefit.

22 Section VII consists of Schedules 46 through 48, providing the administrative  
23 expense estimates and calculations.

1                   Section VIII consists of Schedules 49 through 51, and calculates the required  
2   monthly subscription rates for Organ Transplant coverage.

3                   Section IX consists of Schedules 52 through 58, and contains trends and  
4   projection factors. As part of this, under separate cover, Schedule 53 is being submitted on a  
5   confidential basis. This schedule displays trend “Projection Factors” for incurred allowed claims  
6   projections for the various lines of business.

1     **III.     RATING METHODOLOGY USED IN FILING**

2  
3                   Q.     Can you please provide an overview of the approach used by Blue Cross  
4     to calculate the required rates for Class DIR?

5                   A.     Yes. The actuarial development of required rates for this filing is similar  
6     to the methodology used last year. However, since a full twelve months of claims data under the  
7     new product portfolio was available, it was not necessary to develop claims at the new product  
8     benefit level using the old product portfolio data. This fact significantly simplified the rating  
9     methodology utilized in this year's rate filing. The basic approach was to begin with base period  
10    incurred allowed claims, separately for Basic (Pool I) and Preferred (Pool II) and by benefit plan.  
11    To avoid seasonality concerns we chose a twelve month base period which is our usual practice.  
12    We chose a base period that consists of allowed claims incurred over the 4/1/2006 to 3/31/2007  
13    time frame. This represents the first twelve months of data under the new redesigned product  
14    portfolio. These allowed claims, expressed on a per contract per month (PCPM) basis, were then  
15    projected to the rate period using projection factors which reflect anticipated trends in allowed  
16    claims levels and then adjusted to reflect the anticipated savings arising out of the Radiology  
17    Management program. Finally, the projected rate period allowed claims were adjusted by a  
18    factor that represents the ratio of net claims paid to allowed claims for each benefit plan. These  
19    "net-to-allowed" factors were calculated based on the projected rate period claims so that the  
20    effect of trend leveraging would be accounted for. A more thorough description of trend  
21    leveraging is included later on in my testimony. This process produced projected paid claims  
22    PCPM for each of the products within Basic (Pool I) and Preferred (Pool II). The composite  
23    projected paid claims PCPM was then calculated for each pool.

1           The next major stage in the rate development was to determine the required  
2   monthly base rates for each of the four products within Basic (Pool I) and Preferred (Pool II).  
3   This stage begins with the composite projected incurred claims expense PCPM for each pool,  
4   which I have just described. The impact of state assessments was then applied to the projected  
5   incurred claims cost. The detail behind the state assessments is in Section IV. To this expense  
6   was added retention (administrative expense, investment income credit, contribution to reserve,  
7   and taxes) to calculate required income PCPM by pool and then overall for Class DIR. Note that  
8   in this year's rate filing, the "Contribution to reserve/Tax Liability" component includes an  
9   additional 1.1% to account for the newly enacted state premium assessment. This assessment  
10   was enacted on June 21, 2007 to be effective January 1, 2008. Also, this year's filing includes a  
11   component intended to collect revenue to fund a new core system for claims payment and other  
12   business functions. The development of this new system is consistent with Blue Cross' goal to  
13   simplify and streamline systems and processes. The new "core system" is discussed in more  
14   detail in the pre-filed testimony of Mr. Thomas Boyd. Consistent with the required monthly  
15   income PCPM values are calculated required loss ratios for each pool and overall for Class DIR.

16           The overall required income PCPM for Class DIR is the amount that must be  
17   produced by the base rates for Class DIR as a whole. The separate amounts PCPM for Basic  
18   (Pool I) and Preferred (Pool II) would be the amounts used in developing the base rates for each  
19   of the pools, respectively, if the separate experience of the two pools were to form the sole basis  
20   for rates. This experience has not been the basis used in the past, and we chose not to use it as  
21   the sole basis in this filing. Instead, we elected to partially reflect the separate experience of the  
22   two pools. Thus experience adjusted loss ratios were calculated for Basic (Pool I) and Preferred  
23   (Pool II) for use in developing their respective revenue PCPM amounts.

1           The experience-adjusted projected loss ratio for Basic (Pool I) was set by deciding  
2   to increase Basic (Pool I) rates by a uniform 15% (after taking into account the impact of the  
3   Wellness Health Benefit Plan). As discussed earlier in my testimony, the 15% rate increase was  
4   chosen as a reasonable compromise between our desire to keep Pool I rates affordable and our  
5   desire to reduce the Pool II subsidy of Pool I rates. As mentioned earlier in my testimony, this  
6   year's rate filing includes a component to recognize the implementation of the new Wellness  
7   Health Benefit Plan (WHBP). Since the cost of implementing the new WHBP is approximately  
8   0.5% across all Direct Pay plans, a Basic (Pool I) target rate increase of 14.5% was imposed at  
9   this step to achieve a 15% rate increase once WHBP is taken into account. The methodology for  
10   determining the cost of the WHBP is discussed later on in this testimony. Finally, since the  
11   overall projected loss ratio for Class DIR should not change as a result of this alignment of rates  
12   between pools, the corresponding experience-adjusted projected loss ratio and experience-  
13   adjusted required income PCPM for Preferred (Pool II) were then calculated directly.

14           The last step in calculating base rates was to apply rate relativity factors, by  
15   product, to the pool experience-adjusted composite required base rate amounts PCPM and  
16   adjusting for the impact of the WHBP. These calculations and results are presented in the  
17   schedules contained in Section III. The "Rate Relativity Factors" are the same as those used in  
18   last year's filing.

19           The final stage in the rate development was to apply age/gender, individual and  
20   family rate, and rate-tier normalization factors to the base rates, by product and pool, and to  
21   incorporate Organ Transplant rates, in order to produce the monthly subscription rates. These  
22   calculations and results are presented in the schedules contained in Sections I and II for Basic  
23   (Pool I) and Preferred (Pool II) respectively.

1                   Q.     In your description of the basic approach taken to develop the required  
2 rates, you state that the starting point was base period incurred allowed claims, as opposed to  
3 base period incurred claims expense amounts. Please describe the difference and why allowed  
4 claims were used instead of claims expense.

5                   A.     The difference between allowed claims and claims expense is attributable  
6 to deductibles, coinsurance, and co-payments amounts, which are the responsibility of the  
7 subscriber. Claims expense reflects the benefit payment amounts under the terms of the  
8 particular product. Allowed claims include both claims expense amounts and subscriber cost-  
9 sharing amounts. It is the total cost of covered services under the provider contracts maintained  
10 by Blue Cross prior to the determination of subscriber cost-sharing, versus Blue Cross benefit  
11 payments.

12                   Claims expense varies widely from one product to another if the benefit  
13 provisions differ significantly, and products with relatively large deductibles have claims  
14 expense levels which are skewed during the course of a year, due to deductible accumulations.  
15 In addition, the year-to-year increase in claims expense is leveraged by fixed dollar cost-sharing  
16 – such as deductibles and per service copayments. The impact of these characteristics is  
17 exacerbated when the mix of subscribers by product is changing. Allowed claims, by contrast,  
18 do not vary in these ways. In the rate development, base period allowed claims were used as the  
19 starting point in order to deal most effectively with these issues.

20                   Q.     Later in your description of the basic approach taken to developing the  
21 required rates, you indicate that the projected allowed claims were adjusted to reflect the  
22 anticipated savings from the Radiology Management Program and then adjusted to the net

1 benefit level using net-to-allowed factors. Please explain how the factors to accomplish this  
2 were developed.

3 A. The radiology Management program was discussed in last year's rate filing and  
4 will be effective January 1, 2008. The adjustment factor is calculated separately for Outpatient  
5 and Surgical/Medical services as the expected savings divided by the base period claims  
6 expense.

7 We also used net-to-allowed factors to adjust the projected allowed dollars to the claims  
8 level anticipated to be paid by Blue Cross under each benefit plan. Blue Cross used a re-  
9 adjudication process to develop net to allowed factors, which reflect the ratio of claims expense  
10 to allowed claims for the benefits under a given product. This methodology is consistent with  
11 last year's filing and similar to that employed by Blue Cross in the past to estimate the impact of  
12 changes in benefit costs. The first step in the calculation of non-drug net-to-allowed factors for  
13 the HealthMate Direct 400 and HealthMate Direct 2000 plans and in the calculation of total net-  
14 to-allowed factors for HealthMate for HSA 3000 and HealthMate for HSA 5000 plans was to  
15 project incurred allowed claims for Class DIR from the twelve month base period ending March  
16 31, 2007 to the twelve month rate projection period ending March 31, 2009. The projected rate  
17 year allowed claims were then re-adjudicated to the payment level anticipated under each of the  
18 respective benefit plans. The ratio of the projected rate period claims at the level paid under the  
19 benefit provisions to the total allowed claims level is what we refers to as a "net-to-allowed"  
20 factor. The key benefit provisions that were recognized for each of the re-adjudications are  
21 shown in the schedules contained in Section VI. For the calculation of the drug net-to-allowed  
22 factors, the projected allowed claims were re-adjudicated to the level of benefits anticipated in

1 the rating period, including the change in benefits and pricing due to the new Specialty Pharmacy  
2 program.

3 Q. Why did you start by projecting claims at an allowed dollar basis and then  
4 applying factors to adjust them back to the net benefit payment level, instead of simply  
5 projecting the base period claims expense into the rate year?

6 A. There were a couple of complications with using the net claims expense  
7 to project to the rate year. First, as mentioned earlier, the effect of trend leveraging must be  
8 accounted for. Briefly, trend leveraging describes the phenomenon that for benefit plans with  
9 fixed-dollar cost sharing, claims on a net paid dollar basis increase at a faster rate than claims on  
10 an allowed dollar basis if the fixed-dollar cost sharing (i.e. deductibles and co-payments) does  
11 not change from year to year. For example, let's say that the underlying increase in medical  
12 costs (i.e. the trend in allowed claims) is ten percent annually. Let's further assume that in a  
13 given year, one hundred dollars of allowed claims is incurred. As mentioned earlier, the trend in  
14 allowed dollars is ten percent and one hundred ten allowed dollars are incurred in the following  
15 year. However, if we impose a fifty dollar deductible on the benefit plan, the net claims expense  
16 becomes fifty dollars (\$100-\$50) in the first year and sixty dollars in the following year (\$110-  
17 \$50). The annual trend in claims expense in this case has been "leveraged" to 20% (\$60 divided  
18 by \$50). The same phenomenon occurs in the Direct Pay products due to the upfront deductibles  
19 and other fixed-dollar co-payments in the benefit provisions. Since members do not utilize  
20 benefits consistently, the effect of "deductible leveraging" is best handled by projecting and re-  
21 adjudicating claims at the member level. This is the process involved in the calculation of the  
22 "net to allowed" factors.

1           Secondly, the base experience used in the rate calculations involves the first twelve  
2   months of experience under the re-designed product portfolio. Because the new products  
3   included deductibles that are determined on an annual basis and because these plans became  
4   effective in the middle of the year (April 2006), the annual deductibles were prorated for some  
5   members and carried over to the new products for others in this first year. Therefore the claims  
6   paid over the base period used in this filing are thus not wholly representative of the claims to be  
7   expected for the upcoming rating period. The approach taken in this rate filing also deals with  
8   this issue by starting with an allowed dollar claims base thus ignoring the prorated deductibles in  
9   the base experience period. The experience period is projected on an allowed dollar basis and re-  
10   adjudicated to the deductible and cost sharing levels that will be in effect during the rating  
11   period.

12           Q.     Toward the latter part of your description of the basic approach taken to  
13   develop the required rates, you describe the determination of experience-adjusted composite  
14   required base rate amounts PCPM by pool. Is the composite of these Basic (Pool I) and  
15   Preferred (Pool II) amounts simply the required average rate PCPM for the entire Class DIR?

16           A.     Yes, that is correct.

17           Q.     You indicate that Blue Cross elected to target a 15% rate increase for  
18   Basic (Pool I) in adjusting rate relations between pools. Is that correct?

19           A.     Yes.

20           Q.     If Blue Cross had elected to use 100% of the experience difference in  
21   developing the rates, how would the required rates have differed from those filed?

1           A.     If the full experience difference had been reflected, Preferred (Pool II)  
2 rates would have been about 21% lower, and Basic (Pool I) rates would have been about 9%  
3 higher.

4           Q.     If, alternatively, Blue Cross had elected to use none or 0% of the  
5 experience difference in developing the rates, how would the required rates have differed from  
6 those filed?

7           A.     If none of the experience difference had been reflected, Preferred (Pool II)  
8 rates would have been about 4% higher, and Basic (Pool I) rates would have been about 2%  
9 lower.

10          Q.     From an actuarial perspective, do you believe it is appropriate to reflect  
11 some or all of the experience difference between pools in developing the required rates?

12          A.     From an actuarial perspective, I believe that doing so is warranted and  
13 appropriate. Although the two pools are part of the same Class DIR, they have separate  
14 eligibility requirements; and as a result the two pools have different risk characteristics and  
15 different experience levels.

16          Q.     Near the end of your description of the basic approach taken to developing  
17 the required rates, you indicate that the final step in calculating base rates was to apply product  
18 rate relativity factors to the pool experience-adjusted composite required base rate amounts  
19 PCPM and adjusting for WHBP. Please explain how this was done.

20          A.     The product rate relativity factors were applied in the same manner as  
21 previous filings to develop required monthly base rates for each product. The rate relativity  
22 factors are the same as used in last year's rate filing.

1           The Wellness Health Benefit Plan, if approved, will be implemented on the HealthMate  
2   Direct 2000 Plan. Participants in this program will receive a reward equal to ten percent of their  
3   annual paid premiums provided they comply with the program requirements. The cost of these  
4   rewards is calculated based on the assumption that twenty-five percent of the current HealthMate  
5   Direct 2000 enrollees will participate in the wellness reward program and is applied equally to  
6   the base rates for all benefit plans. Further details regarding the proposed program are discussed  
7   in the pre-filed testimony of Mr. Thomas Boyd.

8           Q.     At the very end of your description of the required rate development, you  
9   indicate that the monthly subscription rates include a rate component for Organ Transplants.  
10   Why are there separate rates for this coverage, and how were they determined?

11          A.     Blue Cross purchases 90% reinsurance coverage for Organ Transplants,  
12   through BCS Insurance Company. As a result, the rate development for Organ Transplants is  
13   based on current reinsurance rates for this coverage, grossed up to a 100% level, trended to the  
14   rate period, and adjusted for certain retention components (investment income credit, new system  
15   charges and contribution to reserve/tax contribution). The resulting required rates are then added  
16   into the final monthly subscription rates. The details behind the Organ Transplant components  
17   are illustrated in Section VIII.

18          Q.     Please turn to Section IV and describe for us the schedules that are  
19   contained in this section.

20          A.     Section IV starts with Schedule 25. Schedule 25 is titled "Calculation of  
21   Claims Impact of State Assessments" and illustrates the different assessments that have an  
22   impact on the rates being filed for Class DIR. The total impact of these is also shown at the

1 bottom. The detail behind each of these calculations is supplied in Schedules 26 through 28.

2 The total impact of these elements is 1.12% to claims expense.

3 Q. Can you please run through each of the schedules 26 through 28 that you  
4 just mentioned and describe those for us?

5 Schedule 26 is titled "Calculation of Claims Impact of Child Immunization  
6 Assessment". This assessment will be made as a percentage of premium at an estimated rate of  
7 0.65%, which we translate into a factor equal to 0.65% of projected claims.

8 Schedule 27 is titled "Calculation of Claims Impact of Adult Immunization  
9 Assessment". This assessment will be made as a percentage of premium at an estimated rate of  
10 0.22%, which we translate into a factor equal to 0.22% of projected claims.

11 Schedule 28 is titled "Calculation of Claims Impact of CEDARR, CIS, and Home  
12 Services". This assessment will be made as a percentage of premium at an estimated rate of  
13 0.255%. This has an overall impact on Class DIR projected claims of 0.25%.

14 Q. Have State Assessments of the above sort been included in Class DIR  
15 rates in the past?

16 A. Yes. These State Assessments were included in the Class DIR rate filing  
17 effective April 1, 2007.

18 Q. Is it appropriate to include these assessments in the rate calculations for  
19 the Class DIR line of business?

20 A. Yes. The determination of these assessments to Blue Cross is based on  
21 premium reported on annual financial statements, including premium for the Class DIR line of  
22 business. In addition, the size of these assessments has grown significantly and we are  
23 concerned that they may continue to grow in the future. As such, we don't believe we can

1 absorb these costs in our other lines without threatening our competitive standing in those market  
2 segments. We believe that the only appropriate way of insulating DIR from these costs (if  
3 indeed the Legislature wishes to so insulate DIR) is to define future bases for assessments in  
4 such a way as to exclude DIR business.

1 **IV. REQUIRED CLASS DIR BASIC (POOL I) AND PREFERRED (POOL II)**  
2 **MONTHLY SUBSCRIPTION RATES**

3  
4 Q. Please turn to Schedule 30 of Blue Cross Exhibit 2 and describe that  
5 schedule.

6 A. Schedule 30 is entitled "Calculation of Composite Paid Claims Expense  
7 Per Contract Month for April 1, 2008 Billing Cycle." The purpose of this schedule is to display  
8 the Base Period Contract Months and the Projected Incurred Claims PCPM by pool and plan. It  
9 uses the projected claims expense for each product from schedules 31 through 34 for Basic (Pool  
10 I) and schedules 35 through 38 for Preferred (Pool II). Calculations are documented in the  
11 footnotes.

12 Q. Please turn to Schedule 31 of Blue Cross Exhibit 2 and describe that  
13 schedule.

14 A. Schedule 31 is entitled "Calculation of Projected Paid Claims per Contract  
15 Month for April 1, 2008 Billing Cycle for HealthMate Direct 400." It applies to Basic (Pool I)  
16 only. The purpose of this schedule is to display the calculation of the "Projected Paid Claims  
17 PCPM" for HealthMate Direct 400 for Basic (Pool I). Calculations are documented in the  
18 footnotes.

19 Q. How does Schedule 31 compare with Schedules 32 through 34?

20 A. Schedules 32 through 34 are comparable in nature. They also apply to  
21 Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct  
22 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas Schedule  
23 31 applies to HealthMate Direct 400.

1 Q. On a column-by-column basis, would you explain what is contained in  
2 Schedules 31 through 34? Please note any relevant differences among them.

3 A. The first and second columns of each of these schedules show base period  
4 "Incurred Allowed Claims" for each of the respective products. As indicated in the applicable  
5 footnotes, and as I indicated earlier in my testimony, allowed claims were tabulated prior to the  
6 application of deductibles, coinsurance, or copayments. We used a base period for tabulating  
7 these allowed claims, and for the contract months underlying Column (2), of April 2006 through  
8 March 2007. Incurred allowed claims amounts for this base period reflect actual claim  
9 submissions through May 2007, adjusted to a fully complete basis.

10 Column (3) shows the "Projection Factors" used to incorporate trends into the  
11 projection of allowed claims PCPM for the rate period. The "Projection Factors" are developed  
12 in Schedule 53, as indicated in the footnotes. Consistent "Projection Factors" are used in all four  
13 schedules.

14 Column (4) shows the "Radiology Management Factor" used to account for the  
15 savings anticipated for the Radiology Management program to be effective January 1, 2008. The  
16 "Radiology Management Factor" is developed in Schedule 40, as indicated in the footnotes.

17 Column (5) displays the Projected Allowed Claims PCPM. This column is the  
18 product of Columns (2) through (4).

19 Column (6) displays the Net-to-Allowed factors by benefit. These factors convert  
20 the projected allowed claims to paid claims for the rate year. The factors are unique to each  
21 combination of pool and plan since these factors are calculated using the actual claims  
22 experience for each pool and plan combination. Since the HealthMate Direct 400 and  
23 HealthMate Direct 2000 products have first dollar coverage for drug benefits (i.e. drug benefits

1 are covered without members first having to meet a deductible), separate net to allowed factors  
2 are calculated for these products. The HealthMate for HSA 3000 and HealthMate for HSA 5000  
3 products cover drug benefits only after the deductible has been met. Therefore, net-to-allowed  
4 factors for these products are calculated in aggregate for drug and non-drug benefits. The  
5 calculations for these factors are displayed in Schedules 41 through 45.

6 Column (7) is the product of Columns (5) and (6). Column (7) represents the  
7 Projected Paid Claims PCPM by benefit for the rate year.

8 Q. You state that Schedules 31 through 34 apply to Basic (Pool I) only. Are  
9 there comparable schedules for Preferred (Pool II)?

10 A. Yes. They are Schedules 35 through 38.

11 Q. Are there any differences between Schedules 35 through 38 and Schedules  
12 31 through 34, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

13 A. No. The same calculations are carried out, and the same issues are  
14 present.

15  
16  
17 **[Pages 27 to 30 are intentionally omitted as they have been filed**  
18 **separately on a confidential basis under seal]**

1                   Q.     With regard to the "Utilization / Mix Trend Factors" shown in Schedule  
2 53, you state that they were developed from an analysis by your staff of historical trends for  
3 Commercial group. Please describe the nature of this analysis.

4                   A.     The utilization / mix trend analysis undertaken by my staff focused on  
5 inpatient hospital days for the Hospital Inpatient line of business, and on allowed claims PCPM  
6 that have been adjusted to a common price level, namely June 2004, for the Hospital Outpatient  
7 and Surgical / Medical lines of business. For Preferred Rx, allowed claims PCPM without any  
8 price adjustment were analyzed.

9                   The data points used in this analysis were 12-month moving values, beginning  
10 with the period ending May 2005. Twenty-five data points, which equates to three years of  
11 experience, were chosen to provide a meaningful measurement period and to be consistent with  
12 previous rate filings. Trend lines were fit to a number of sets of data points utilizing the method  
13 of linear least squares, a statistical technique for quantifying trend levels. Following standard  
14 Blue Cross procedures, calculations were made to determine the line that best fit the data points  
15 using the most recent 13 or more data points, with a minimum R-squared value of 0.70 to help  
16 assure reasonable fit to the data points.

17                  The annual trend indicated by the least squares line producing the best fit under  
18 this procedure is then selected as the basis for the trend assumption, provided the result is  
19 acceptable actuarially. Adjustment or modification to this result, or substitution of an alternative  
20 assumption, may occur if it is not reasonable or appropriate in our actuarial judgment.

21                  Q.     Could you please elaborate on the least squares calculation method?

22                  A.     This is the method that has been utilized and presented in past rate filings  
23 for quantifying trends. It has been discussed extensively in previous rate hearings. Briefly, by

1 plotting a number of historical observations on a graph, the average change over a specified time  
2 period may be calculated using a statistical technique referred to as the method of linear least  
3 squares.

4 For the observations plotted on the graph, a general trend – either up, down or  
5 neutral – may be observed by visual inspection of the line plotted on the graph. That is, it may  
6 be possible to detect that a succession of points on the graph are generally higher than, lower  
7 than, or about the same as the previous points. The method of linear least squares quantifies this  
8 average change in values over time by use of a statistical computation.

9 The principle of least squares states that the line of best fit to a series of observed  
10 values is the line where the sum of the squares of the deviations (the differences between the line  
11 and the actual values) are minimal or the “least” possible. While one may attempt to draw a  
12 straight line through the observations by visual interpretation to denote a trend, the method of  
13 least squares obtains that minimum sum of squared deviations necessary to give a best linear fit  
14 of the data.

15 Q. Would you please describe the methodology in terms of the number of  
16 data points used in order to find the best fit?

17 A. Yes. We considered a total of 25 monthly 12-month moving data points.  
18 The number of data points consisting of the most recent 13 or more points that provide the best  
19 fit was calculated, as I just described. There was no discretion in the selection of the number of  
20 data points; it was mathematically determined. There is only one possible best fit, which is the  
21 number of data points that produces the line with the highest R-squared value.

22 Once the number of 13 or more of the most recent data points that provides the  
23 best fit is found, the trend indication based on those data points is what we utilize in the rate

1 calculations, provided that the “best fit” is actuarially acceptable. A trend line within an R-  
2 squared value of 0.70 or higher is generally considered statistically acceptable to us; however,  
3 information to the contrary, such as a non-credible experience base or an erratic or biased pattern  
4 of data points, in addition to a low R-squared value, or when the result is unreasonable, may  
5 provide reasons to utilize actuarial judgment in trend determination.

6 Q. In your opinion, is the use of less than 13 of the most recent monthly 12-  
7 month data points appropriate as an actuarial method for quantifying utilization / mix?

8 A. No. In my opinion, fewer than 13 of these points do not provide sufficient  
9 historical data from which to measure an underlying trend level.

10 Q. Does Blue Cross consistently use at least 13 monthly 12-month data points  
11 in the calculation of the best fit whether or not it provides to Blue Cross a higher rate than some  
12 other number of data points?

13 A. Yes, provided the best fit produces results that are actuarially acceptable.

14 Q. Is a good fit a valid measure of an underlying trend?

15 A. In the absence of information to the contrary, it normally is a reasonable  
16 indicator.

17 Q. As a matter of statistical principle, is it correct that the better the fit, the  
18 greater the validity of the trend measurement?

19 A. Yes.

20 Q. Is the choice of the best fit within a displayed number of data points  
21 discretionary?

22 A. No. There is only one best linear fit. One cannot pick and choose best  
23 fits.

1 Q. Would you briefly describe what “utilization” is and what “mix” is as  
2 these terms have been used in the various schedules and in your testimony?

3 A. “Utilization” refers to the rate of use of covered services by subscribers.  
4 “Mix” of services refers to the change in distribution of claims amounts by factors affecting the  
5 amounts such as changes in the types of claims, procedures and services performed, providers  
6 rendering service and other changes in the types of services used as opposed to the rate of use.

7 Q. Were there any adjustments made to the data used for the trend analysis  
8 you just described?

9 A. Yes. Certain adjustments were made to normalize for changes in benefits  
10 or pricing policies that have occurred over the experience period used to measure trend. Also,  
11 certain modest adjustments were made to the allowed claims PCPM under Preferred Rx, in order  
12 to reflect global changes in the pricing, quantities, and over-the-counter dispensing of certain  
13 specific prescription drugs. Lastly, the experience of certain large groups was excluded from the  
14 trend analyses. These groups represented accounts with a large number of employees living out  
15 of state, and thus would not be reflective of Rhode Island specific experience.

16 Q. Are you satisfied with the appropriateness of these adjustments to the  
17 data?

18 A. Yes.

19 Q. Please turn to Schedule 54, and describe what is contained in that  
20 schedule. Schedule 54 is entitled “Hospital Inpatient: Historical Days per 1,000 Members and  
21 Utilization Trends.” This schedule contains a graph displaying annual inpatient days per 1,000  
22 members for 25 monthly 12-month moving periods or data points, for Commercial groups. The

1 data points begin with the 12-month period ending May 2005 and continue through the 12-month  
2 period ending May 2007.

3 Trend lines were fit to a number of sets of data points utilizing the method of  
4 linear least squares, as I described earlier. Following standard Blue Cross procedures,  
5 calculations were made to determine the line that best fit the data points with a minimum of the  
6 most recent two years of data (the most recent 13 data points or more). As shown in Schedule  
7 54, the line with the best fit is based on the most recent 13 data points with an R-squared value of  
8 0.8917 and an annual trend of 2.85%. Since the R-squared value met our minimum criteria of  
9 0.70, and there was no information to the contrary, a 2.85% annual trend was selected for  
10 Hospital Inpatient. This annual trend assumption is documented in the footnotes contained in  
11 Schedule 53.

12 Q. Please turn to Schedule 55, and describe what is contained in that  
13 schedule.

14 A. Schedule 55 is entitled "Hospital Outpatient: Historical Allowed Claims  
15 PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims  
16 per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The  
17 data points begin with the 12-month period ending May 2005 and continue through the 12-month  
18 period ending May 2007. In order to reflect only changes in utilization and mix of services, the  
19 allowed claims amounts have been adjusted, or "depriced," to June 2004, so that intervening  
20 price increases have been removed from the allowed claim PMPM values used.

21 Trend lines were fit to a number of sets of data points utilizing the method of  
22 linear least squares referred to in describing Schedule 54 earlier. Similarly, following standard  
23 Blue Cross procedures, calculations were made to determine the line that best fit the data points

1 with a minimum of the most recent two years of data. As shown in Schedule 55, the line with  
2 the best fit is based on 21 data points, which has an R-squared value of 0.9499 and represents a  
3 calculated annual trend of 1.62%. However, a utilization trend of 1.62% is historically low.  
4 Therefore, a trend of 2.02%, based on the regression with all 25 data points, was used as a more  
5 reasonable level of utilization/mix increases. The regression based on all 25 data points has a  
6 still very valid R-squared value of 0.9189. This annual trend assumption is documented in the  
7 footnotes contained in Schedule 53.

8 Q. Please turn now to Schedule 56, and describe what is contained in that  
9 schedule.

10 A. Schedule 56 is entitled "Surgical/Medical: Historical Allowed Claims  
11 PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims  
12 PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the  
13 12-month period ending May 2005 and continue through the 12-month period ending May 2007.  
14 In order to reflect only changes in utilization and mix of services, the allowed claims amounts  
15 have been adjusted, or "depriced," to June 2004, so that intervening price increases have been  
16 removed from the allowed PMPM values used.

17 Again, trend lines were fit to a number of sets of data points utilizing the method  
18 of linear least squares. Following standard Blue Cross procedures, calculations were made to  
19 determine the line that best fit the data points with a minimum of the most recent two years of  
20 data. As shown in Schedule 56, the line with the best fit is based on 18 data points, which has an  
21 R-squared value of 0.9935 and represents a calculated annual trend of 5.19%. Since the R-  
22 squared value met our minimum criteria of 0.70, and there was no information to the contrary, a

1 5.19% annual trend was selected for Surgical/Medical. This annual trend assumption is  
2 documented in the footnotes contained in Schedule 53.

3 Q. Please turn to Schedule 57, and describe what is contained in that  
4 schedule.

5 A. Schedule 57 is entitled "Preferred Rx: Historical Allowed Claims PMPM  
6 and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims  
7 PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the  
8 12-month period ending May 2005 and continue through the 12-month period ending May 2007.  
9 These values have not been deprecised, so their trends reflect both price and utilization/mix.

10 The line exhibiting the best fit produced an annual trend of 9.59%. It consisted of  
11 13 data points, with an R-squared value of 0.9984. Actuarial judgment was exercised by Blue  
12 Cross, however. Visual inspection of the graph and an analysis of annual trends by month  
13 suggest that the regression trend using 13 data points is dampened by an aberrantly low trend for  
14 March 2007 over March 2006. Therefore, the trend using all 25 data points was selected to  
15 minimize the impact of this aberration. The trend using all 25 data points has an R-squared value  
16 of 0.9983 (nearly identical to the highest R-squared regression line), and a calculated annual  
17 trend of 10.48%. This annual trend assumption is documented in the footnotes contained in  
18 Schedule 53.

19 Q. Would you turn now to Schedule 58, and describe what is contained in  
20 that schedule?

21 A. Schedule 58 is entitled "Point Values Utilized in Development of Trends."  
22 This schedule displays the inpatient days per 1,000 members and allowed claims PMPM values  
23 utilized to calculate trends in Schedules 54 through 57. The first column shows the dates

1 applicable to each of the 25 monthly 12-month periods observed. Opposite each date are the  
2 values reflected in the various graphs set forth in Schedules 54 through 57 for each of the  
3 applicable lines of business.

4 Q. With regard to the "Radiology Management Factor" shown in Column (4)  
5 of schedules 31 through 38, you refer to its development in Schedule 40. Could you please turn  
6 to Schedule 40 and describe that schedule?

7 A. Schedule 40 is entitled "Calculation of Radiology Management Savings  
8 Factors for Surgical/Medical and Outpatient." It applies to Basic (Pool I) and Preferred (Pool II).  
9 This schedule represents the savings associated with implementing a preauthorization program  
10 on certain high-end radiology procedures. This program will be implemented effective January  
11 1, 2008. The decrease in utilization of high-end radiology services is estimated to be 7.5%. The  
12 impact of this utilization decrease is calculated separately for the Surgical/Medical and  
13 Outpatient lines of business. Calculations are documented in the footnotes.

14 Q. Turning back to the description of Schedules 31 through 38, you  
15 mentioned the development of the Net-to-Allowed factors on Schedules 41 through 45. Could  
16 you please describe generally the method used to develop these "Net-to-Allowed Factors"?

17 A. Sure. To determine Net to Allowed, the allowed claims for each Direct  
18 Pay member are "re-priced" to simulate members having each of the current plan designs. The  
19 base period claims were broken out by each pool and product combination and each category  
20 was used in the calculation of the Net-to-Allowed factor for that particular cohort. For example,  
21 only the base period claims for Basic (Pool I) HealthMate Direct 400 were "re-priced" in the  
22 calculation of the Net-to-Allowed factor applicable to that pool and product. Since the base

1 period used begins in the middle of the calendar year and deductibles are aggregated on a  
2 calendar year basis, a multi-step process was utilized to project and re-adjudicate the claims.

3 First, allowed claims for the period January 2007 through March 2007 were discounted  
4 back to the period January 2006 through March 2006. These discounted claims were combined  
5 with claims from the period April 2006 through December 2006 to form a calendar year base  
6 consisting entirely of new product portfolio experience. The calendar year base was then  
7 projected to CY 2008 and re-adjudicated to the net payment level for the applicable benefit plan.

8 Next, allowed claims for the period January 2007 through March 2007 were projected to  
9 the period January 2009 through March 2009 and re-adjudicated to the net benefit level. This  
10 data were combined with the last nine months of projected net claims data from the previous step  
11 to form the net claims for the rating period. The "Net to Allowed Factor" is then the ratio of the  
12 projected net claims expense to the projected rate year allowed claims.

13 The prescription drug net to allowed calculations for the HealthMate for HSA 3000 and  
14 the HealthMate for HSA 5000 products are incorporated into the medical net to allowed  
15 calculations, since prescription drug claims for these plans apply towards the deductible. For the  
16 HealthMate Direct 400 and HealthMate Direct 2000 products, separate calculations are  
17 performed for medical and drug claims.

18 Q. Now please turn to Schedule 41 and describe that schedule.

19 A. Schedule 41 is entitled "Calculation of Non-Drug Net to Allowed Factor  
20 for HealthMate Direct 400 Plan." The "Net-to-Allowed Factor" values, as I have just described,  
21 reflect the ratio of claims expense under a product to allowed charges.

22 Schedule 41 shows and documents the development of the "Net-to-Allowed  
23 Factors" for non-drug services for the HealthMate Direct 400 plan, separately for Basic (Pool I)

1 and Preferred (Pool II). It is needed to adjust projected incurred claims from an allowed claims  
2 basis to a claims expense basis under the HealthMate Direct 400 plan.

3 Q. Would you please explain each of the Lines in Schedule 41?

4 A. Line 1 displays the "Projected Incurred Allowed Claims" used in the  
5 development of the "Net to Allowed Factor" for non-drug services for the HealthMate Direct 400  
6 plan. As indicated in the footnotes, the amount shown in Line 1 is the total non-drug allowed  
7 claims incurred during the base year April 2006 through March 2007 and projected to the 12-  
8 month rate period beginning April 2008.

9 Line 2 shows the "Adjusted Net Amount" corresponding to the projected incurred  
10 allowed claims in Line 1. This "Adjusted Net Amount" reflects the net amount of claims  
11 expense, after subscriber cost sharing. As I generally described earlier in my testimony, it was  
12 developed by re-adjudicating the allowed claims in Line 1, reflecting the benefit provisions for  
13 non-drug services under the HealthMate Direct 400 plan.

14 Line 3 contains the "Net to Allowed Factor" for non-drug services for the  
15 HealthMate Direct 400 plan. It is calculated as the ratio of Line 2 to Line 1, as indicated in the  
16 footnotes.

17 Q. You also refer to Schedules 42 through 45, in addition to Schedule 41, as  
18 providing the development and documentation for the "Net to Allowed Factors" contained in  
19 Schedules 31 through 38. Please describe Schedules 42 through 45.

20 A. Schedule 41 develops and documents the "Net to Allowed Factor" for  
21 non-drug services for the HealthMate Direct 400 plan. The corresponding development is  
22 presented in Schedules 42 through 45 for non-drug services under the HealthMate Direct 2000  
23 product, total services (drug and non-drug) under the HealthMate for HSA 3000 product, total

1 services (drug and non-drug) under the HealthMate for HSA 5000 product, and drug services  
2 under the proposed 20%/25%/50%/\$75 Preferred Rx stand-alone product, respectively.

3 Q. Are there any differences between Schedules 42 through 45 and Schedule  
4 41, other than applying to different product options?

5 A. No. Comparable re-adjudication calculations were carried out by Blue  
6 Cross, depending on the coverage (drug vs. non-drug vs. combined) and product benefit  
7 provisions. The calculations in the schedules are the same.

8 Q. You have now described and explained the columns in Schedules 31  
9 through 38, along with the various schedules supporting them. You have stated that Schedules  
10 31 through 38 develop the "Projected Paid Claims PCPM" for each of the current products.

11 Now I would like to turn to Section III of the rate filing and the development of  
12 the monthly base rates. Please turn to Schedule 18 and describe that schedule.

13 A. Schedule 18 is entitled "Calculation of Required Monthly Base Rates for  
14 April 1, 2008 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to  
15 display the calculation of the "Required Monthly Base Rates" for each of the products under  
16 Basic (Pool I). Calculations are documented in the footnotes.

17 Q. On a column-by-column basis, please explain what is contained in  
18 Schedule 18.

19 A. Column (1) contains the number of contract months by product. It is used  
20 for weighting various amounts.

21 Column (2) shows the "Composite Required Monthly Base Rate" for Basic (Pool I). This  
22 value represents the projected overall average rate required from Basic (Pool I) subscribers. As  
23 indicated in the footnotes, this PCPM value is developed in Schedule 21.

1 Column (3) contains the “Rate Relativity Factors” for each of the current products. I  
2 mentioned previously in my testimony that these factors are the same as utilized in last year’s  
3 approved filing.

4 Column (4) shows the Basic (Pool I) “Required Monthly Base Rate Without WHBP” for  
5 each of the four products. Calculations are documented in the footnotes. The “Rate Relativity  
6 Factors” in Column (3) are used to calculate the separate “Required Monthly Base Rates” for  
7 each product, consistent with the overall “Composite Required Monthly Base Rate” in Column  
8 (2).

9 Column (5) shows the monthly reward PCPM offered to HealthMate Direct 2000  
10 enrollees who participate in and fulfill the requirements for the Wellness Health Benefit Plan.

11 Column (6) displays the Projected WHBP Participation Rate of 25% for HealthMate  
12 Direct 2000 enrollees. Although ultimately the participation rate is expected to be high, Blue  
13 Cross recognizes that there will be some inertia to overcome in terms of the initial enrollment  
14 rate. In addition, members are expected to enroll gradually throughout the year. Therefore, a  
15 25% average participation rate seems reasonable in the first year of the program.

16 Column (7) calculates the net premium collected after WHBP rewards are taken into  
17 account. Note that Column (7) is identical to Column (4) for each plan with the exception of  
18 HealthMate Direct 2000 since this is the only product eligible for WHBP rewards.

19 Column (8) calculates the required monthly base rates after accounting for the expected  
20 WHBP rewards. The calculations are documented in the footnotes.

21 Q. You state that Schedule 18 applies to Basic (Pool I) only. Is there a  
22 comparable schedule for Preferred (Pool II)?

23 A. Yes. It is Schedule 19.

1 Q. Are there are differences between Schedule 19 and Schedule 18, other  
2 than applying to Preferred (Pool II) vs. Basic (Pool I)?

3 A. No.

4 Q. With regard to the “Composite Required Monthly Base Rate” in Column  
5 (2) of Schedules 18 and 19, you refer to their development in Schedule 21. Could you please  
6 turn to Schedule 21 and describe that schedule?

7 A. Schedule 21 is entitled “Calculation of Composite Required Monthly Base  
8 Rates for April 1, 2008 Billing Cycle.” This schedule applies to both Basic (Pool I) and  
9 Preferred (Pool II). Its purpose is to display the calculation of the “Composite Required Monthly  
10 Base Rate,” by pool. Calculations are documented in the footnotes.

11 Q. On a column-by-column basis, would you please explain what is  
12 contained in Schedule 21?

13 A. Column (1) contains the number of “Contract Months” for each pool, and  
14 Column (2) contains the “Projected Incurred Claims Including Mandates” for each pool. The  
15 sources of these values are documented in the footnotes. Note that the values in Column (1) are  
16 from Schedule 30, and the values in Column (2) are from Schedule 23.

17 Column (3) shows the “Required Loss Ratio, Full Experience Basis” for Basic  
18 (Pool I) and Preferred (Pool II). These ratios are the required loss ratios by pool that would be  
19 appropriate for use in developing the composite required monthly base rate if the separate  
20 experience for each of the two pools were to be fully used as the basis for developing the  
21 respective monthly subscription rates. The “Required Loss Ratios, Full Experience Basis” in  
22 Column (3) are developed in Schedule 23.

Column (4) shows the “Required Loss Ratio, Current Pool Rate Alignment Basis” for Basic (Pool I) and Preferred (Pool II). These ratios are the required loss ratios by pool that would be appropriate for use in developing the composite required monthly base rates if the current rate relationships or alignment for the two pools were to be fully maintained as the basis for developing the respective monthly subscription rates. The “Required Loss Ratios, Current Pool Rate Alignment Basis” in Column (4) are developed in Schedule 22.

Column (5) shows the “Required Loss Ratio, Experience Adjusted Basis” for Basic (Pool I) and Preferred (Pool II). These are required loss ratios by pool that are appropriate for use in developing the composite monthly base rates in order to incorporate partial recognition of the separate experience for each of the two pools, along with partial recognition of the current pool rate alignments. For Basic (Pool I), a 15% rate increase was targeted to produce the “Required Loss Ratio, Experience Adjusted Basis.” As mentioned earlier, the target rate increase for Basic (Pool I) at this step is 14.5%, so that the Basic (Pool I) rate increase after WHBP rewards are taken into account is 15%. The corresponding value for Preferred (Pool II) is then calculated so as to retain unchanged the composite value for the pools combined. The calculations involved in Column (5) are documented in the footnotes.

Column (6) contains the “Composite Required Monthly Base Rate” for Basic (Pool I) and Preferred (Pool II). These two PCPM values incorporate the new rate alignment between pools, consistent with partial recognition of the separate experience of the two pools, as reflected by the “Required Loss Ratios, Experience-Adjusted Basis” in Column (5). Note that the composite Class DIR required loss ratio remains unchanged through this rate re-alignment process.

1 Q. With regard to the “Required Loss Ratios, Full Experience Basis,” you  
2 refer to their development in Schedule 23. Could you please turn to Schedule 23 and describe  
3 that schedule?

4 A. Schedule 23 is entitled “Calculation of Required Loss Ratios on Full  
5 Experience Basis for April 1, 2008 Billing Cycle.” It applies to both Basic (Pool I) and Preferred  
6 (Pool II). The purpose of the schedule is to display the calculation of the “Required Loss Ratios,  
7 Full Experience Basis” for each of the two pools. Calculations are documented in the footnotes.

8 Q. On a column-by-column basis, would you explain what is contained in  
9 Schedule 23?

10 A. Column (1) of Schedule 23 shows the contract months for Basic (Pool I)  
11 and Preferred (Pool II).

12 Column (4) shows the projected claims expense PCPM including the impact of  
13 state assessments for each of the two pools. This is the product of Columns (2) and (3). The  
14 sources of these values are documented in the footnotes.

15 Column (5) contains the “Administrative Expense PCPM” for the rate period. As  
16 indicated in the footnotes, the value contained in Column (5) is developed in Schedule 47.

17 Column (7) contains the “Investment Income Credit PCPM” amounts. The  
18 investment income credit is the amount by which required subscription income is reduced due to  
19 anticipated earnings from invested funds.

20 The investment income credit is calculated by looking at three values that  
21 generate funds used to produce investment earnings, namely, the reserve level of the Class in  
22 question, prepaid subscriptions, and claim reserves. These amounts, after adjusting for only  
23 those funds that will be available for investment, are used to generate earnings. Based on a

1 projection of such amounts, a determination was made of the appropriate investment income  
2 credit factor, expressed as a percent of projected incurred claims and administrative expense.  
3 This calculation produced the investment income credit factor of 0.20% indicated in the  
4 footnotes to Schedule 23. This investment income credit factor was then used to calculate the  
5 “Investment Income Credit PCPM” shown in Column (7) of Schedule 23.

6 Column (8) contains the rating component for the new “core system” mentioned  
7 previously and discussed in more detail in the pre-filed testimony of Mr. Thomas Boyd. Blue  
8 Cross proposes to collect the revenue required to implement the new claims payment system by  
9 way of a charge on rates equal to 0.5%. Calculations are documented in the footnotes.

10 Column (9) contains the “Contribution to reserve/ Tax Liability PCPM” values  
11 for the rate period. The contribution to reserve and tax liability component is the amount  
12 requested by Blue Cross to include in the Class DIR subscription rates in order to contribute to  
13 the establishment and maintenance of reserves maintained by Blue Cross for the protection of its  
14 subscribers. As mentioned earlier, the “Contribution to reserve / Tax Liability” component  
15 includes an additional 1.1% for the recently enacted state premium tax assessment on health  
16 insurance premiums. The tax is levied pursuant to P.L. 2007, ch. 73, as enacted by House Bill  
17 5300 Substitute A as amended, Article 28 Substitute A as amended, which amended in relevant  
18 parts R.I.G.L. 27-20-2, 44-17-1, and 44-17-2. This bill (i.e. the budget) was enacted on June 21,  
19 2007, with Article 28 becoming effective January 1, 2008.

20 The factor used to calculate Column (9) is based on the requested contribution to  
21 reserve as a percentage of income plus one quarter of the amount for federal income taxes plus  
22 an additional 1.1% for the aforementioned state premium assessment. Thus, in this case, the

1 contribution to reserve of 1% requires 0.25% for federal taxes (20% of the pre-tax gain). The  
2 combined contribution to reserve and tax PCPM is then calculated using a factor of 0.9765.

3 The remaining columns in Schedule 23 are calculated using the values I just  
4 described. These calculations are documented in the footnotes. Column (11) then contains the  
5 "Required Loss Ratios" calculated for Basic (Pool I) and Preferred (Pool II), on a full experience  
6 basis. That means that the Basic (Pool I) value reflects the projected required loss ratio based  
7 fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

8 Q. With regard to the "Administrative Expense PCPM" shown in Column (5)  
9 of Schedule 23, you refer to its development in Schedule 47. Could you please turn to Schedule  
10 47 and describe that schedule?

11 A. Schedule 47 is entitled "Calculation of Administrative Expense per  
12 Contract Month for April 1, 2008 Billing Cycle." It applies to both Basic (Pool I) and Preferred  
13 (Pool II). The purpose of this schedule is to weight together Blue Cross' administrative expense  
14 PCPM amounts for 2008 and 2009 from Schedule 48, to produce an appropriate amount for the  
15 April 1, 2008 billing cycle.

16 Q. Would you please turn to Schedule 48 and explain what that is?

17 A. Schedule 48 is entitled "Calculation of Calendar Year 2008 and Calendar  
18 Year 2009 Administrative Expense per Contract Month." It applies to both Basic (Pool I) and  
19 Preferred (Pool II). Schedule 48 displays the calendar year 2008 and 2009 administrative  
20 expense budget amounts, in aggregate and PCPM. These projections are based on methodology  
21 that is explained in the testimony of Mr. Thomas Boyd.

22 Q. Please turn back to Schedule 23. In your testimony regarding Column (9)  
23 of this schedule, you described the nature of the "Contribution to reserve / Tax Liability PCPM"

1 and its calculation. You also indicate that a factor of .9765 was used, in order to produce an  
2 after-tax contribution to reserve of 1% of subscription income. Is that correct?

3 A. Yes.

4 Q. Is this the standard contribution to reserves?

5 A. No. A factor of .9640 would have produced our standard after-tax  
6 contribution to reserve of 2%. In this filing, our senior management team and Board of Directors  
7 determined that the reserve factor should be reduced in order to produce a contribution to reserve  
8 of 1%. This was done to moderate the necessary rate increase for Class DIR.

9 Q. What is the reserve status of Class DIR?

10 A. The Class DIR reserve position at September 30, 2007 was \$(5,876,926),  
11 or (1.35) months in reserve. The Class DIR reserve position at March 31, 2008 is projected to be  
12 approximately \$(8.0) million. The Class DIR reserve position at March 31, 2009 is projected to  
13 be approximately (\$7.2) million assuming income at the rates proposed by Blue Cross in this  
14 filing. These reserve positions are indicated on a Statutory Accounting Principles (SAP) basis  
15 and assume no unrealized capital gains or losses.

16 Q. What is the corporate reserve status of Blue Cross?

17 A. Blue Cross' reserve position at September 30, 2007 was \$418,996,207, or  
18 2.98 months in reserve, on a SAP basis.

19 Q. Please turn back to Schedule 21. In your testimony pertaining to Schedule  
20 21, you describe three required loss ratio bases. Is that correct?

21 A. Yes.

1 Q. The first of these three required loss ratio bases you describe is the "Full  
2 Experience Basis" in Column (3), which you describe in your testimony pertaining to Schedule  
3 23. Is that also correct?

4 A. Yes.

5 Q. The second of these three required loss ratio bases you describe is the  
6 "Current Pool Rate Alignment Basis" in Column (4), which you indicate is developed in  
7 Schedule 22. Is that correct?

8 A. Yes.

9 Q. Please turn to Schedule 22 and describe that schedule.

10 A. Schedule 22 is entitled "Calculation of Required Loss Ratios on Current  
11 Pool Rate Alignment Basis for April 1, 2008 Billing Cycle." It applies to both Basic (Pool I) and  
12 Preferred (Pool II). The purpose of the schedule is to display the calculation of the "Required  
13 Loss Ratio, Current Pool Rate Alignment Basis" for each of the two pools. Calculations are  
14 documented in the footnotes.

15 The overall Class DIR "Required Income PCPM" is developed in Schedule 23.  
16 The same overall Class DIR "Required Income PCPM" is preserved in Schedule 22. The  
17 respective amounts by pool, however, differ between Schedule 23 and 22. In Schedule 23, the  
18 "Required Income PCPM" amounts by pool directly reflect the separate experience of each pool.  
19 Schedule 22 develops "Required Income PCPM" amounts by pool which reflect the current  
20 alignment of rates by pool, rather than pool experience. In both cases, Schedules 23 and 22, the  
21 composite average "Required Income PCPM" must remain the same.

22 Q. On a column-by-column basis, would you explain what is contained in  
23 Schedule 22?

1           A.     Column (1) of Schedule 22 shows the contract months for Basic (Pool I)  
2     and Preferred (Pool II). Column (2) shows the “Projected Incurred Claims Including Mandates”  
3     amounts for each of the two pools. The sources of these values are documented in the footnotes.

4           Column (3) contains the composite “Required Income PCPM” amount for Class  
5     DIR as a whole. This amount is developed in Schedule 23, which I described earlier in my  
6     testimony.

7           Column (4) contains the “Present Rate Income PCPM” (PRI) amounts on an  
8     average basis for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The composite  
9     average PRI for all of Class DIR is weighted by the contract months in Column (1), as  
10    documented in the footnotes.

11          Column (5) contains the “Current Pool Rate Alignment Basis Required Income  
12    PCPM” amounts for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The  
13    calculations are documented in the footnotes. The Class DIR composite in Column (5) is  
14    required to be the same as in Column (3), as I just discussed in my testimony. The respective  
15    “Required Income PCPM” amounts by pool in Column (5) are calculated to maintain the same  
16    proportionate relationship as the PRI values in Column (4), i.e., no re-alignment in rates between  
17    pools.

18          Column (6) contains the “Required Loss Ratios” calculated for Basic (Pool I) and  
19    Preferred (Pool II), on a current pool rate alignment basis. This means that the Basic (Pool I) and  
20    Preferred (Pool II) values would retain the same relationship in required rates as is reflected in  
21    the present rates.

1 Q. Please turn back to Schedule 21 once again. You have now described the  
2 development of the "Required Loss Ratios, Full Experience Basis" in Column (3) and the  
3 "Required Loss Ratios, Current Pool Rate Alignment Basis" in Column (4). Is that correct?

4 A. Yes.

5 Q. The third of the three required loss ratio bases, shown in Column (5) of  
6 Schedule 21, is labeled the "Required Loss Ratio, Experience Adjusted Basis." You explain this  
7 third set of required loss ratios in your testimony as being based on a blending of the preceding  
8 two sets of required loss ratios. You state that the "Required Loss Ratio, Experience Adjusted  
9 Basis" in Column (5) was then used by Blue Cross in calculating the "Composite Required  
10 Monthly Base Rates" in Column (6). Is all this correct?

11 A. Yes.

12 Q. Please turn to Schedule 20 and describe that schedule.

13 A. Schedule 20 is entitled "Rate Change Comparison of Minimum Pool II  
14 Loss Ratio and Proposed Loss Ratios". The purpose of this schedule is to demonstrate the  
15 resulting rate changes by pool using the 70% Pool II loss ratio recommended in last year's rate  
16 decision compared to the rate changes proposed by Blue Cross in this year's rate filing. Note  
17 that the rate changes shown on this schedule are prior to the recognition of the WHBP impact  
18 and Organ Transplant rates.

19 Q. On a column by column basis, please explain what is contained on  
20 Schedule 20.

21 A. Column (1) displays the base period contract months for Basic (Pool I)  
22 and Preferred (Pool II). Columns (2) and (3) display the Present Rate Income PCPM and  
23 Projected Incurred Claims respectively.

Columns (4) through (6) show the rate change calculations if the 70% loss ratio recommended in last year's decision was used as the basis for aligning the rates between pools. Column (4) shows the loss ratios by pool. Preferred (Pool II) is set at 70% and Basic (Pool I) is calculated so that the premium for Class DIR as a whole is equal to the overall required premium. Column (5) displays the resulting base rates by pool and Column (6) displays the resulting rate changes by pool under the 70% Pool II loss ratio scenario.

Columns (7) through (9) are comparable in nature to Columns (4) through (6) except that they apply to the pool rate alignment proposed in this rate filing. As mentioned earlier, the pool rate alignment proposed in this rate filing targets a 15% rate increase for Pool I, after WHBP rewards are applied. The Composite Required Base Rates in Column (8) are carried forward and used in the calculation of monthly subscription rates in the preceding schedules.

Q. Why did Blue Cross choose this alternate pool rate alignment, rather than the one based on a Pool II loss ratio of 70% as recommended in the last rate decision?

A. As this schedule demonstrates, rate changes, prior to including the impact of the WHBP and Organ Transplant, under the 70% Pool II loss ratio scenario would be a 21% increase for Basic (Pool I) and a 6% decrease for Preferred (Pool II). As discussed earlier in this testimony, we feel that it would not be in the best interest of our subscribers to decrease Preferred (Pool II) rates while giving a large increase to Basic (Pool I) members. Therefore, we felt that targeting a 15% rate increase for Basic (Pool I) represented a good compromise between keeping Basic (Pool I) rates affordable while still reducing the cross subsidy that Pool II provides to Pool I.

Q. Please turn now to Schedule 6 and describe that schedule.

1           A.     Schedule 6 is entitled “Calculation of HealthMate Direct 400 Required  
2     Monthly Subscription Rates for April 1, 2008 Billing Cycle.” It applies to Basic (Pool I) only.  
3     The purpose of this schedule is to display the calculation of the monthly subscription rates for  
4     Individual and Family subscribers in Basic (Pool I), separately for subscribers under age 65  
5     versus age 65 and over. Monthly subscription rates in Schedule 6 are shown separately on a  
6     “Required Rate” basis. Calculations are documented in the footnotes.

7           Q.     How does Schedule 6 compare with Schedules 7 through 9?

8           A.     Schedules 7 through 9 are comparable in nature. They also apply to Basic  
9     (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000,  
10    HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas Schedule 6  
11    applies to HealthMate Direct 400.

12          Q.     On a column-by-column basis, would you explain what is contained in  
13    Schedules 6 through 9?

14          A.     Column (1) contains the “Monthly Base Rate” for each of the  
15    corresponding products for Basic (Pool I). As indicated in the footnotes, the “Monthly Base  
16    Rates” for Basic (Pool I) are developed in Schedule 18.

17                 Column (2) is labeled “Rate Tier Normalization Factor.” This is the  
18    normalization factor that corrects any imbalance in the “Rate Factors” contained in Columns (4)  
19    and (6) of Schedules 6 through 9, determined across the entire pool. The “Rate Tier  
20    Normalization Factor” is developed in Schedule 10.

21                 Column (3) is simply Column (1) divided by Column (2).

22                 Column (4) contains the “Individual Rate Factors,” and Column (6) contains the  
23    “Family Rate Factors.” These are the factors needed to convert the “Normalized Monthly Base

1 Rate” for the product and pool to “Monthly Subscription Rates” for Individual and Family  
2 contracts and, within each, for under age 65 and age 65 and over subscriber rating categories.  
3 The factors contained in Columns (4) and (6) are based on the current rate relationships between  
4 individual vs. family subscribers, by under and over age 65. The rate factors used are the same  
5 factors that were approved in last year’s rate filing for class DIR.

6 Columns (5) and (7) contain the “Monthly Subscription Rates” for the Individual  
7 and Family subscriber categories respectively. The calculations are documented in the footnotes.  
8 In addition to using the “Normalized Monthly Base Rates” and “Rate Factors” contained within  
9 the schedules, the calculation of the “Monthly Subscription Rates” also includes a rate  
10 component for Organ Transplants. The development of this rate component is contained in  
11 Schedule 50.

12 Q. With regard to the “Rate Tier Normalization Factor” in Column (2) of  
13 Schedules 6 through 9 you refer to its development in Schedule 10. Could you please turn to  
14 Schedule 10 and describe that schedule?

15 A. Schedule 10 is entitled “Calculation of Rate Tier Normalization Factor”.  
16 Column (1) is the “Rate Factor” that converts monthly normalized base rates to monthly  
17 subscription rates for “Individual”, “Family”, “Under 65”, and “Ages 65 and Over” rating  
18 categories. These are the same factors used in last year’s filing.

19 Columns (2), (3), (4), and (5) represent the Base Period Contract Months for each  
20 of the current products.

21 Column (6) is just an aggregation of the 4 preceding columns.

22 Lines (1) through (5) simply represent the enrollment by tier category and in total.

1 Row (6) represent the “Rate Relativity Factors” that, as I mentioned previously,  
2 are the same as from last year’s filing.

3 The remaining lines show the computational steps, as explained in the footnotes.

4 Q. With regard to the “Monthly Subscription Rates” in Columns (5) and (7)  
5 of Schedules 6 through 9 you refer to the development of a rate component for Organ  
6 Transplants in Schedule 50. Could you please turn to Schedule 50 and describe that schedule?

7 A. Schedule 50 is entitled “Organ Transplant, Calculation of Required  
8 Monthly Subscription Rates.” It applies to both Basic (Pool I) and Preferred (Pool II). The  
9 purpose of this schedule is to display the calculation of the required monthly subscription rates  
10 for Organ Transplant coverage. Calculations are documented in the footnotes.

11 Q. Please describe the status of Class DIR Organ Transplant coverage.

12 A. Blue Cross has been purchasing solid organ and bone marrow transplant  
13 reinsurance for Class DIR from BCS Insurance Company commencing with the rate filing for  
14 rates effective April 1, 1988. Given the relatively small Class DIR population, coupled with the  
15 high costs of individual claims in this area and the uncertainty of the exposure arising out of this  
16 coverage, Blue Cross determined that reinsurance was appropriate for both solid organ transplant  
17 and bone marrow transplant coverage.

18 The organ transplant reinsurance coverage from BCS Insurance covers 90% of the  
19 claims risk. Acquisition of the reinsurance is transparent to the subscribers. The proposed rates  
20 in this filing for organ transplant coverage reflect the reinsurance capitation per contract month,  
21 plus an amount reflecting the 10% claims risk that Class DIR has retained.

22 Q. Please explain what is contained in Schedule 50.

1                   A.     Columns (1) and (2) of Schedule 50 reflect the Individual and Family  
2 values for solid organ transplant coverage; Columns (3) and (4) reflect the same information for  
3 bone marrow transplant coverage. Line 1 reflects the 90% reinsurance capitation rates per  
4 contract month for the BCS Reinsurance in 2008. Line 2 reflects the corresponding projected  
5 Blue Cross exposure at 10% for the same period, based on the BCS capitation levels. Line 4  
6 contains the composite projection factors, which are developed in Schedule 51. Line 6 contains  
7 the investment income credit per contract month, and Line 7 contains the new  
8 system/contribution to reserve/tax liability per contract month. The calculations of these lines  
9 are documented in the footnotes. Both are computed in a manner similar to that used for the  
10 Blue Cross underwritten portion of the products in Class DIR, as described in Schedule 23.

11                   Q.     With regard to the “Composite Projection Factors” in Line 4 of this  
12 schedule, you refer to their development in Schedule 51. Could you please turn to Schedule 51  
13 and describe that schedule?

14                   A.     Schedule 51 is entitled “Organ Transplant, Calculation of Composite  
15 Projection Factors for Incurred Claims Expense.” This schedule shows the development of the  
16 “Composite Projection Factors” used in Line 4 of Schedule 50. The projected increases were  
17 obtained directly from BCS Insurance Company. Schedule 51 weights these projected increases  
18 with the appropriate number of months within the rate period from calendar years 2008 and  
19 2009.

20                   Q.     Please turn back now to Schedule 6. You described the calculations  
21 involved in Columns (5) and (7) of Schedule 6. The result is what is shown in these two  
22 columns as the Basic (Pool I) “Monthly Subscription Rates” for HealthMate Direct 400. Is that  
23 correct?

1                   A.     Yes. The resulting “Monthly Subscription Rates” are contained in  
2 Columns (5) and (7) for Individual and Family subscribers, respectively.

3                   Q.     Schedule 6 applies to the HealthMate Direct 400 product under Basic  
4 (Pool I). You testify that Schedules 7 through 9 are comparable, for the other three product rates  
5 for Basic (Pool I). Is that also correct?

6                   A.     Yes.

7                   Q.     You state that Schedules 6 through 9 apply to Basic (Pool I), for each of  
8 the four products being offered. Are there comparable schedules for Preferred (Pool II)?

9                   A.     Yes. Schedules 12 through 15 correspond to Schedules 6 through 9, for  
10 Preferred (Pool II) versus Basic (Pool I). Schedule 16 also corresponds to Schedule 10.

11                  Q.     Please turn to Schedule 12. Are the same calculations carried out for the  
12 HealthMate Direct 400 product in Schedule 12 for Preferred (Pool II) as in Schedule 6 for Basic  
13 (Pool I)?

14                  A.     The same types of calculations are carried out in Schedule 12 for Preferred  
15 (Pool II) as in Schedule 6 for Basic (Pool I).

16                  I would note that the format and structure of Schedule 12 differs slightly from  
17 Schedule 6; labeling and rate development is consistent, however. The structural difference  
18 occurs since Preferred (Pool II) has separate Individual rates for Male vs. Female subscribers,  
19 and has rates for subscribers under age 65 that vary by age band.

20                  Q.     You state that Schedules 12 through 15 for each of the Preferred (Pool II)  
21 products correspond to Schedules 6 through 9 for Basic (Pool I). You have just described  
22 Schedule 12. Are there any differences between Schedules 13 through 15 and Schedule 12, other  
23 than applying to the other products under Preferred (Pool II)?

1                   A.     No. The same calculations are carried out, and the same issues are  
2    present.

## V. CONCLUSION

Q. Are the rates developed in Exhibit 2 and displayed in Schedules 6 through 9 and 12 through 15 consistent with rates presented in your letter dated November 15, 2007 and included as Blue Cross Exhibit 1?

A. Yes, the rates in these two documents are the same.

Q. Were Blue Cross Exhibit 2, Schedules 1 through 58 prepared by you or under your direction and supervision?

A. Yes. These schedules were prepared by my staff in the Actuarial and Statistical Analysis Department of Blue Cross.

Q. Were Blue Cross Exhibit 2, Schedules 1 through 58 prepared using generally accepted actuarial principles and were those principles consistently applied?

A. Yes.

Q. Is it your opinion, to a reasonable degree of actuarial certainty, that Blue Cross Exhibit 2, Schedules 1 through 58, reflect fair, accurate and reasonable computations of required rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

A. Yes.